



Relistor Prior Authorization

**Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Relistor must meet the following guidelines:

- Diagnosis of opioid-induced constipation
- Inability to tolerate oral medications or
- Failed two oral medications

Note:

***Polyethylene glycol powder is covered without a prior authorization.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Prescriber Name					
Prescriber Medicaid Provider Number		Telephone Number		Fax Number	
Address		City		State	Zip Code
Requested Drug and Dosage: <input type="checkbox"/> Relistor		Diagnosis for this request:			
Qualifications for coverage:					
FIRST FAILED MEDICATION		START DATE:		END DATE:	
SECOND FAILED MEDICATION		START DATE:		END DATE:	
<input type="checkbox"/> INABILITY TO TOLERATE ORAL MEDICATIONS					
Prescriber Signature				Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
PHONE NUMBER	FAX NUMBER	DRUG		NDC #	

Part III: FOR OFFICIAL USE ONLY

Date Received				Initials:	
Approved - Effective dates of PA: From: / / To: / /				Approved by:	
Denied: (Reasons)					